IDAPA 16
TITLE 03
Chapter 10

16.03.10 - RULES GOVERNING MEDICAID PROVIDER REIMBURSEMENT IN IDAHO

000. LEGAL AUTHORITY.

Title XIX (Medicaid) of the Social Security Act, as amended, is the basic authority for administration of the federal program (see 42 CFR Part 447). Title 56, Chapter 1, Idaho Code, establishes standards for provider payment. Section 56-202, Idaho Code, provides that the Department is responsible for administering the program. Further it authorizes the Department to take necessary steps for its proper and efficient administration. (7-1-99)T

01. General. (7-1-93)

a. Fiscal administration of the Idaho Title XIX Medicaid Program will be in accordance with these rules and the Federal (42 CFR Part 447 Provider Reimbursement Manual (PRM) Part I and Part II, HCFA Publication 15-1 and 15-2, which is hereby incorporated by reference. These materials are available from HCFA, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the internet @ http://www.access.gpo.gov/nara/cfr/cfr-table-search.html). The provisions shall apply unless otherwise authorized. (7-1-99)T

b. Generally accepted accounting principles, concepts and definitions shall be followed in determining acceptable accounting treatments except as otherwise provided. (1-16-80)

02. Compliance As Condition Of Participation. Compliance with the provisions in this chapter, its amendments, and additions is required for participation in the Idaho Title XIX (Medicaid) Program. (7-1-99)T

001. TITLE.

The rules in this chapter are to be cited in full as Idaho Department of Health and Welfare Rules, IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho". (12-31-91)

002. REIMBURSEMENT PROVISIONS FOR STATE OWNED OR OPERATED ICF/MR FACILITIES.

Provisions of these rules do not apply to ICF/MR facilities owned or operated by the state of Idaho. Reimbursement of such facilities will be governed by the principles set forth in the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars ($5,000). (7-1-99)T

003. ADMINISTRATIVE APPEALS.

Hearings will be conducted in conformance with IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings And Declaratory Rulings". (7-1-99)T

004. DEFINITIONS.

01. Accrual Basis. An accounting system based on the matching principle. Revenues are recorded when they are earned; expenses are recorded in the period incurred. (1-16-80)

02. Allowable Cost. Costs which are reimbursable, and sufficiently documented to meet the requirements of audit. (1-16-80)

03. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (1-16-80)

04. Appraisal. The method of determining the value of property as determined by a MAI appraisal. The appraisal must specifically identify the values of land, buildings, equipment and goodwill. (9-15-84)

05. Assets. Economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles. (1-1-82)

06. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (1-16-80)

07. Bed-Weighted Median. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (7-1-99)T

08. Beneficiaries. Persons who are eligible for and receive benefits under federal health insurance programs such as Title XVIII and Title XIX. (1-16-80)

09. Betterments. Improvements to assets which increase their utility or alter their use. (1-1(

10. Capitalize. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (1-16-80)

11. Case Mix Component. The portion of the facility's rate, direct care component, that is determined from quarterly case mix indices. The case mix component of a facility's rate is established at the beginning of each calendar quarter, based on the case mix indices calculated on the picture date of the preceding quarter. (7-1-99)T

12. Case Mix Index. A numeric score assigned to each facility resident, based on the resident's physical and mental condition, which projects the amount of relative resources needed to provide care to the resident. (7-1-99)T

a. Facility Wide Case Mix Index. The average of the entire facility's case mix indices identified at each picture date during the cost reporting period. If case mix indices are not available for applicable quarters due to lack of data, case mix indices from available quarters will be used. (7-1-99)T

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG's classification. Medicaid or non-Medicaid status will be based upon information contained in claims and MDS databases. To the extent that Medicaid identifiers are found to be incorrect at the time of the audit, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (7-1-99)T

c. State-Wide Average Case Mix Index. The simple average of all facilities "facility wide" case mix indices used in establishing the reimbursement limitation July 1 of each year. The state-wide case mix index will be calculated annually during each July 1 rate setting. (7-1-99)T

13. Common Ownership. An individual, individuals, or other entities which have equity, or evidence ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (7-1-99)T

14. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (1-16-80)

15. Control. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (7-1-99)T

16. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or material which are related or so considered for cost-accounting purposes. (1-16-80)

17. Cost Component. The portion of the facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a facility's rate is established annually at July 1 of each year.(7-1-99)T

18. Cost Reimbursement System. A method of fiscal administration of Title XIX which compensates the provider on the basis of expenses incurred. (1-16-80)

19. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (7-1-99)T

20. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (1-16-80)

21. Costs Related To Patient Care. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. (7-1-99)T

22. Costs Not Related To Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are not allowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (7-1-99)T

23. Customary Charges. Customary charges are the regular rates for various services which are recorded for patients liable for such charges. Those charges are to be adjusted downward, where the provider does not impose such charges on most patients liable for payment on a charge basis or, fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt (see Chapter 3, Sections 310 and 312, PRM). (7-1-99)T

24. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the provider. However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (7-1-97)

25. Department. The Department of Health and Welfare of the state of Idaho. (1-16-80)

26. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (1-1-82)

27. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (7-1-99)T

a. Direct nursing salaries which include the salaries of registered nurses, licensed professional nurses, certified nurse's aides, and unit clerks; and (7-1-99)T

b. Routine nursing supplies; and (7-1-99)T

c. Nursing administration; and (7-1-99)T

d. Direct portion of Medicaid related ancillary services; and (7-1-99)T

e. Social services; and (7-1-99)T

f. Raw food; and (7-1-99)T

g. Employee benefits associated with the direct salaries. (7-1-99)T

28. Director. The Director of the Department of Health and Welfare or his designee. (1-

29. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (9-15-84)

30. Facility. An entity which contracts with the Director to provide services to recipients in a structure owned, controlled, or otherwise operated by such an entity, and which entity is responsible for operational decisions in conjunction with the use of the term "facility": (1-1-82)

a. The term "Nursing Facility" or "NF" is used to describe all non-ICF/MR facilities certified to provide care to Medicaid and Medicare patients; (2-1-91)

b. "Free-standing Nursing Facility" means a nursing facility, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in Section 39-1301(a), Idaho Code; or (9-28-90)

c. "Hospital-based Nursing facility" means a nursing facility, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which is owned, managed, or operated by, or is otherwise a part of a hospital, as defined in Section 39-1301(a), Idaho Code. (7-1-99)T

d. "Rural Hospital-Based Nursing Facilities." Those hospital-based nursing facilities not located within metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (7-1-99)T

e. "Urban Hospital-Based Nursing Facilities." Those hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (7-1-99)T

31. Fiscal Year. The business year of an organization. (1-16-80)

32. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (11-4-85)

33. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (1-16-80)

34. GAAP. Generally accepted accounting principles, pronounced "gap". (1-16-80)

35. Generally Accepted Accounting Principles. Those concepts, postulates, axioms, etc., which are considered standards for accounting measurement. (1-16-80)

36. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is nonallowable, nonreimbursable expense. (9-15-84)

37. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (1-1-82)

38. ICF/MR. An intermediate care facility for the mentally retarded. (9-15-84)

39. ICF/MR Living Unit. The specific property or portion thereof that an ICF/MR uses to house patients. (7-1-97)

40. Improvements. Improvements to assets which increase their utility or alter their use. (1-16-80)

41. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (7-1-99)T

a. Administrative and general care costs: and (7-1-99)T

b. Activities; and (7-1-99)T

c. Central service and supplies; and (7-1-99)T

d. Laundry and linen; and (7-1-99)T

e. Dietary (non-"raw food" costs); and (7-1-99)T

f. Plant operations and maintenance (excluding utilities); and (7-1-99)T

g. Medical records; and (7-1-99)T

h. Employee benefits associated with the indirect salaries; and (7-1-99)T

i. Housekeeping; and (7-1-99)T

j. Other costs not included in direct care costs or costs exempt from cost limits. (7-1-99)T

42. Inflation Adjustment. Cost used in establishing a facility's reimbursement rate shall be indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (7-1-99)T

43. Inflation Factor. For use in establishing nursing facility rates, the inflation factor is the Skilled Nursing Facility (SNF) Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. (7-1-99)T

44. Interest. The cost incurred for the use of borrowed funds. (1-16-80)

45. Interest On Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are differentiated from those related to current indebtedness by the payback period of the related debt. (1-16-80)

46. Interest On Current Indebtedness. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are differentiated from others by the fact that the related debt is scheduled for repayment within one (1) year. (1-16-80)

47. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (1%) at the date the loan is made. (7-1-99)T

48. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (10-22-93)

49. Intermediary. Any organization which administers the Title XIX program; in this case the Department of Health and Welfare. (1-16-80)

50. Intermediate Care Facility For The Mentally Retarded. A habilitative facility designed and operated to meet the educational, training, habilitative and intermittent medical needs of the developmentally disabled. (9-15-84)

51. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. (1-16-80)

52. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (1-16-80)

53. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (1-16-80)

54. Level Of Care. The classification in which a patient/resident is placed following a medical/social review decision. (1-16-80)

55. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (1-16-80)

56. Lower Of Cost Or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) shall be the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge shall be reimbursed fair compensation; which is the same as reasonable cost. (7-1-99)T

57. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (9-15-84)

58. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (12-28-89)

a. A relatively fixed location in the building; (11-4-85)

b. Capable of being moved, as distinguished from building equipment; (11-4-85)

c. A unit cost of five thousand dollars ($5000) or more; (7-1-99)T

d. Sufficient size and identity to make control feasible by means of identification tags; and (11-4-85)

e. A minimum life of three (3) years. (7-1-99)T

59. Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of nursing facilities certified to participate in Medicare or Medicaid. The version of the document initially used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (7-1-99)T

60. Medicaid. The 1965 amendments to the Social Security Act (P.L. 89-97), as amended. (1-1

61. Medicaid Related Ancillary Costs. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (7-1-99)T

62. Minor Movable Equipment. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen shall, at the facility's option, be considered minor movable equipment with the cost thereof reported as a medical supply. The general characteristics of this equipment are: (12-28-89)

a. In general, no fixed location and subject to use by various departments of the provider's facility; (11-4-85)

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (7-1-99)T

c. Subject to inventory control; (11-4-85)

d. Fairly large quantity in use; and (11-4-85)

e. Generally, a useful life of less than three (3) years. (7-1-99)T

63. Necessary. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (7-1-99)T

64. Net Book Value. The historical cost of an asset, less accumulated depreciation. (1-1-82)

65. New Bed. A bed is considered new if it is an additional nursing facility bed that is licensed subsequent to July 1, 1999. (7-1-99)T

66. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (7-1-99)T

67. Nonambulatory. Unable to walk without assistance. (11-4-85)

68. Nonprofit Organization. An organization whose purpose is to render services without regard to gains. (1-1-82)

69. Normalized Per Diem Cost. Refers to direct care costs that have been adjusted based on the facility's case mix index for purposes of making the per diem cost comparable among facilities. Normalized per diem costs are calculated by dividing the facility's direct care per diem costs by its facility-wide case mix index, and multiplying the result by the statewide average case mix index. (7-1-99)T

70. Nursing Home Facility. A "Nursing Facility" or "NF". See facility. (9-28-90)

71. Nursing Facility Inflation Rate. The most specific skilled nursing facility inflation rate applicable to Idaho established by Data Resources, Inc. or its successor. If a state or regional index has not been implemented, the national index will be used. (7-1-99)T

72. Ordinary. Ordinary means that the costs incurred are customary for the normal operation of the business. (7-1-99)T

73. Oversight Committee. The Director will appoint an oversight committee to monitor implementation of the Prospective Payment System (PPS) for nursing facility reimbursement that takes effect July 1, 1999. The committee will be made up of at least one (1) member representing each of the following organizations: the Department, the state association(s) representing free standing nursing facilities, and the state association(s) representing hospital-based nursing facilities. The committee will continue to meet periodically subsequent to the implementation of the PPS. After three (3) years of implementation, the committee will examine the inflation factors used to inflate costs forward for rate setting (DRI + one percent (+1%), the inflation factors used in limiting the growth in the cost component limitations (DRI + two percent (+2%), and the level of the minimum cost component limitations (not lower than limits established July 1, 1999) and report its findings and recommendations to the Director who will, at its option, make changes to the prospective system. (7-1-99)T

74. Patient Day. A calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care shall be deemed to exist. (1-1-82)

75. Picture Date. A point in time when case mix indices are calculated for every facility based on the residents in the facility on that day. The picture date to be used for rate setting will be the first day of the second month of a quarter. The picture date from that quarter will be used to establish the facility's rate for the next quarter. (7-1-99)T

76. Private Rate. Rate most frequently charged to private patients for a service or item. (1-16-80)

77. PRM. The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, HCFA Publications 15-1 and 15-2, which are incorporated by reference into these rules. (7-1-99)T

78. Property Costs. The total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (9-15-84)

79. Property Rental Rate. A rate paid per Medicaid patient day to other than hospital based nursing homes in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/MR facilities. (7-1-97)

80. Proprietary. An organization operated for the purpose of monetary gains. (1-16-80)

81. Provider. A licensed and certified skilled nursing or intermediate care facility which renders care to Title XIX recipients. (1-16-80)

82. Prudent Buyer. A prudent buyer is one who seeks to minimize cost when purchasing an item of standard quality or specification (PRM, Chapter 2100). (7-1-99)T

83. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (7-1-99)T

84. Related To Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (7-1-99)T

85. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (7-1-99)T

86. Reasonable Property Insurance. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year shall not be considered reasonable. (11-4-85)

87. Recipient. An individual determined eligible by the Director for the services provided in the state plan for Medicaid. (1-1-82)

88. Related Entities. The provider, to a significant extent, is associated or affiliated with, or is controlled by, or has control of another entity. (1-16-80)

89. Resource Utilization Groups (RUG's). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. For purposes of initial rate setting, RUG's III, version 5.12, 34 Grouper, nursing weights only, with index maximization (a Grouper application that assigns a resident to a group whose reimbursement closely approximates the highest case mix index for the resources being provided) will be used for grouping residents and is hereby incorporated into these rules. The RUG's Grouper is available from HCFA, 7500 Security Blvd., Baltimore, MD, 21244-1850. Subsequent versions of RUG's, or its successor, will be evaluated and may be incorporated into the rate setting process as necessary. The Department is under no obligation to incorporate changes to the RUG's Grouper. (7-1-99)T

90. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (1-16-80)

91. Skilled Nursing Facility. A nursing care facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and certified as a "Nursing Facility" under Title XVIII. (9-28-90)

92. Title XVIII. The Medicare program administered by the federal Heatlh Care Financing Administration. (1-16-80)

93. Title XIX. The medical assistance program known as Medicaid administered by the state of Idaho, Department of Health and Welfare. (1-16-80)

94. Utilities. All expenses for heat, electricity, water and sewer. (9-15-84)

005. -- 049. (RESERVED).

050. CRITERIA FOR PARTICIPATION IN THE IDAHO TITLE XIX PROGRAM.

01. Application For Participation And Reimbursement. Prior to participation in the Medicaid Program the Licensure and Certification Section of the Division of Health, Department of Health and Welfare or its successor organization, certifies a facility for participation in the Program. Their recommendations are forwarded to the Division of Welfare, Division of Medicaid or its successor organization, for approval. The Division of Medicaid or its successor organization issues a provider number to the facility which becomes the primary provider identification number. The Division of Medicaid or its successor organization will need to establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. (7-1-99)T

02. Reimbursement. The reimbursement mechanism for payment to provider facilities is specified in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Rules Governing Medical Assistance". The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. (4-28-89)

051. -- 059. (RESERVED).

060. PROPERTY REIMBURSEMENT.

Facilities other than hospital based nursing facilities will be paid a property rental rate, and shall also be reimbursed the Medicaid share of property taxes and reasonable property insurance. The Medicaid share is determined by the ratio of Medicaid patient days to total patient days. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. However, the property rental rate for ICF/MR shall not include compensation for major movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit for a NF, an interim rate for property reimbursement shall be set to approximate the property rental rate as determined by Sections 56-108 and 56-109, Idaho Code. (7-1-97)

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to Section 061., and, beginning April 1, 1985, shall be:

R = "Property Base" x 40 - "Age" / 40 x "change in building costs" where: (12-31-91)

a. "R" = the property rental rate. (11-4-85)

b. "Property Base" = thirteen dollars and nineteen cents ($13.19) beginning October 1, 1996 for all freestanding nursing facilities but not ICF/MR facilities. Beginning October 1, 1996, the property base rate for ICF/MR - living units shall be eleven dollars and twenty-two cents ($11.22) except for ICF/MR living units not able to accommodate residents requiring wheelchairs. Property base = seven dollars and twenty-two cents ($7.22) for ICF/MR living units not able to accommodate residents requiring wheelchairs. (7-1-97)

c. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. Beginning January 1, 1997, "change in building costs" will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs whichever is greater. For freestanding NF facilities, the index available in September of the prior year will be used; for ICF/MR facilities, the most recent index available when it is first necessary to set a prospective rate for a period that includes all or part of the calendar year, will be used.

(7-1-97)

d. "Age" of facility - The effective age of the facility in years shall be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof shall be assigned an age of more than thirty (30) years, however: (11-4-85)

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age shall be set at thirty (30) years. Adequate documentation shall include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age shall be determined for each building. A weighted average using the age and square footage of the buildings shall become the effective age of the facility. The age of each building shall be based upon the date when construction on that building was completed. This age shall be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula:

r	=	A x E / S x C

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 060.01.d.ii.

If the result of this calculation, "r" is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0).(12-28-89)